Inclusion of Gender and Equity in Maternal, Newborn and Child Health Services in West Africa: A Literature Review of Programming

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Key Points

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Overarching Themes

- **Expanded Program on Immunization (EPI)** and **community-based interventions** are the most common sources of equity-oriented programming
- Push for the implementation of programming to **reduce out-of-pocket spending** such as user-fee exemptions and National Health Insurance Schemes
- **Nation-wide rollouts** preferred over targeting specific populations
- Lack of programs addressing the specific characteristics and power relations that distinguish males and females within communities

Benin

- Overcome **geographical and educational barriers** to equitable health care
- No programs targeting gender inequality

Burkina Faso

- Generate **financial mechanisms** and provide **educational opportunities** to increase access to MNCH services
- **Income generation** and **microcredit** programming to provide women with the resources to access care

Ghana

- Reduce **socio-economic, educational and geographical** barriers to MNCH services
- **Microfinance programming** to increase empowerment and assist in overcoming the socially implemented power structures that impede health care access

Mali

- Improve **quality** of facility services delivery
- Lack of programming aimed at overcoming gender barriers

Nigeria

- Overcoming **geographical barriers** and increasing **vaccination** coverage
- No programs strive to work within power structures surrounding gender to improve the delivery of MNCH services

Senegal

- Focus on **malaria, pregnancy outcomes and nutrition**
- **Empowerment of grandmothers** to utilize their influence to improve the nutritional practices of mothers and their children

Barriers

- Programs often **fail to move beyond geographical, educational and socio-economical differences in populations**, leading to many populations still not receiving adequate MNCH care
- **Lack of inclusion of gender** considerations during the formation of initiatives

Future Steps

- Targeting **disadvantaged populations** through scale-up and adaption
- **Improve communication** among governments and organizations to reduce duplication
- Gender and equity need to be **considered as part of the decision-making process**

Brief

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Background

This brief discusses the inclusion of gender and equity in maternal, newborn and child health (MNCH) programming in the Economic Community of West African States (ECOWAS) countries. It focuses on the context of six countries – Benin, Burkina Faso, Ghana, Mali, Nigeria, and Senegal. Also, it provides an overview of the current MNCH situation in the ECOWAS region. To address maternal health, this brief centers on maternity services[1] and not the broader remit of sexual and reproductive health services[2]. Additionally, it examines child health programming, defined as malnutrition, immunization, IMCI, and community case management of diarrhea, pneumonia, and malaria, but does not address the prevention of maternal to child transmission of HIV, and pediatric AIDS. In terms of gender, this brief explores how programs aim to reduce gender inequalities caused by socially established gender norms and power relations to improve access to MNCH services. Moreover, the brief attempts to identify how programs overcome differences among populations in terms of education, socio-economic status, location/distance to health facility, etc[3]. as a pathway to understanding the extent of the inclusion of equity.

Based upon an extensive desk review of peer-reviewed and grey literature published since 1990, these sources were identified through search engines including PubMed, SCOPUS, Embase, Web of Science, CINAHEL, and Google. This directed search resulted in a list 10,733 articles, 134 of which are included in the final review. The majority of reviewed articles were published in English. However, relevant ones written in French also are incorporated.

Overarching Themes

Throughout the ECOWAS region, the Expanded Program on Immunization (EPI) and community-based interventions[4] represent the two most common sources of equity-oriented programming. Moreover, countries strive to identify and implement mechanisms to reduce out-of-pocket (OOP) spending for MNCH services, including, user-fee exemptions and National Health Insurance Schemes (NHIS). Still, much programming does not target specific populations. Rather, countries prefer nation-wide rollouts of interventions to guarantee equal access. Unfortunately, such approaches do not adequately address the needs of the most-underserved populations.

A lack of programs specifically addressing gender inequity exists in the ECOWAS region. Instead, the majority of interventions attempt to overcome variances between female populations – i.e. differing levels of education and socio-economic status – rather than the specific characteristics and power relations that distinguish males and females

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[1] Antenatal care, childbirth, postpartum care, abortion and post-abortion care, and nutrition

[2] HIV, STIs, family planning, and malaria in pregnancy

[3] Geographical location, education status, ethnicity, socio-economic status, age, household type (family type – polygamous vs. monogamous – marital status, female-headed households, household size), disability, religion and occupation

[4] This includes, but is not limited to: Integrated Community Case Management (ICCM), task-shifting to community health workers, and home-based management

within communities. This represents an opportunity for the ECOWAS region to further improve MNCH service delivery and access.

Country contexts

Benin

In Benin, the majority of reviewed programs aim to overcome geographical and educational barriers to equitable health care. The main strategy to achieve this goal involves community health workers (CHWs) providing health services and education at the community level to reduce the prevalence of malaria and improve both nutrition and the use of primary health care (PHC). For example, UNICEF implemented the Accelerated Child Survival and Development (ACSD) program between 2001 and 2005, which works to increase the coverage of life-saving programs in Benin, and utilizes CHWs to promote ACSD care packages and treat fever and diarrhea at the community level (1). Other key implementers of programs designed to increase health equity include Catholic Relief Service, Freedom from Hunger, the World Health Organization, the Global Fund, Plan International, the United States Agency for International Development and the Beninese government itself (2–9).

No programs to improve MNCH service provision were identified that specifically targeted gender inequality at the household, community, regional, or national levels. This represents a definite barrier to adequate and equitable health care in the country, and provides an opportunity for continued improvement of service provision.

Burkina Faso

In Burkina Faso, a large number of equity-oriented programs aspire to generate financial mechanisms for MNCH services, and to improve mother and child nutrition. The majority of these interventions seek to improve the socio-economic status of beneficiaries through health financing schemes designed to increase access healthcare (3,10,11). Additionally, the government of Burkina Faso implemented a policy in 2006, which subsidizes 80% of obstetric emergency and neonatal care fees (12–14). This further removes the financial barrier to healthcare and allows for non-governmental organizations (NGOs) to more simply subsidize the remaining 20% of service fees (12,15). Improved education also marks a key tenant of equity-oriented programing in Burkina Faso, with many of the finance and nutrition interventions including a learning or community mobilization pillar, which, for example improves understanding of when to seek health care, and what types of foods a mother and child should consume (16–18).

Although many of the reviewed programs in Burkina Faso specifically target women, few attempt to help women overcome barriers they face due to their gender. Still, the limited programs that do strive to reduce gender-related gaps in the provision of services do so through microcredit and income generation programs devised to provide women with the necessary resources to access care (10,19).

Ghana

The majority of reviewed programs in Ghana aim to reduce socio-economic barriers to MNCH services. Programs also work to educate beneficiaries and reduce geographical barriers to care. Two notable programs in Ghana include Project Five Alive! (PFA) and the provision of free maternal care through the NHIS. PFA developed by the National Catholic

Health Service of Ghana and the Institute for Healthcare Improvement in collaboration with the Ghana Health Service, represents a quality improvement intervention focused on delivering low-cost MNCH and nutritional interventions (20–22). To do this, the program employs community outreach interventions to promote health education, and register women to receive health consultations throughout pregnancy. Additionally, in 2008, an exemption for premium fees for maternal health care was added to Ghana's NHIS in an attempt to offset inequalities in access to health care, improve access to ANC and increase facility-based deliveries (23–26).

In addition to Ghana's NHIS, multiple microfinance programs exist that aim to increase women's empowerment and assist them to overcome the socially implemented power structures that impede health care access (27–29). Also, the Navrongo Experiment, based at the Navrongo Health Research Center, specifically targets men through community mobilization activities in order to promote gender equity and overcome gatekeeping of women's health-seeking behavior (30).

Mali

In Mali, a focus arises to improve the quality of facility service delivery to promote the use of MNCH services, and to assure that women in all regions of the country possess access to the same level of quality care. This initiative includes the improvement of and increased accessibility to routine services and comprehensive emergency obstetric care service (31–34). Additionally, the government of Mali has implemented numerous nation-wide interventions, including the Expanded Program on Immunization (EPI) and National Nutritional Weeks, devised to overcome geographical and economical obstacles mothers and children face when attempting to access essential care packages (1,35,36).

None of the identified programs in Mali specifically target overcoming gender barriers to receiving adequate and equitable care. Therefore, an opportunity exists for Mali, as in some of the other reviewed countries, to further improve service delivery.

Nigeria

Overcoming geographical barriers to equitable healthcare represents a stated priority in many of the reviewed MNCH programs in Nigeria. One of the main ways to achieve this goal involves the implementation of innovative mechanisms for transportation between communities and health care facilities. For example, multiple Nigerian schemes encourage partnership between transportation unions and communities to supply emergency transportation when needed, and support community mobilization by creating funds to pay for that transportation (37,38). Additionally, a greater proportion of studied programs in Nigeria than in any other country included this review, concentrate on child immunizations (39–42). To increase coverage, these initiatives often partner with other interventions, such as the preparation and use of oral rehydration therapy (ORT), which helps overcome potential geographical barriers to access of MNCH services (41,43).

As in many of the other appraised countries, none of the considered programs in Nigeria strive to work within the institutionalized power structures surrounding gender to improve the impartial delivery of MNCH services. The lack of this type of programming represents a continued barrier to equitable care, and provides an opportunity for Nigeria to continue to improve service provision.

Senegal

The majority of examined Senegalese programs focus on malaria, pregnancy outcomes and nutrition. Similar to other reviewed countries, these initiatives work to overcome geographical barriers to care by training CHWs to deliver basic and essential care at the community level, and to remove socio-economic barriers by eliminating service fees for both vaginal and caesarian section deliveries (11,44,45). Additionally, many of Senegal's interventions strive to improve the nutritional status of children under five years of age. The Community Nutrition Project (CNP), funded by the World Bank and implemented by the Agence d'Exécution des Travaux d'Intérêt Public[5] (AGETIP) represents one such program, which over a five year period after commencing in 1992, effectively reduced discrepancies in nutritional status between the urban rich and poor (46–49). This dietary program targets participants based on geographic location, i.e. living in historically poor neighborhoods, poor nutritional status of children living in households, etc..

Another Senegalese intervention aims to work within the social power dynamics of that country's society by not only empowering grandmothers, but also utilizing their influence to improve the nutritional practices of mothers and their children (50). This represents an innovative and successful approach to understanding the social norms surrounding gender, while integrating them into a program to improve MNCH health.

Barriers

Currently, the greatest challenge encountered by MNCH programming in West Africa involves the lack of inclusion of gender considerations during the formation of the initiatives. Of the reviewed programs, the vast majority present as either gender-unequal, or gender-blind, resulting in either perpetuation of gender inequality, or disregard of existing social norms, roles and relations (51). These omissions pose serious barriers to the implementation of fully successful and adequate MNCH care, due to the complex gender dynamics within societies in these Western African countries that limit mothers' movements and decision-making abilities when seeking healthcare for their children and themselves (52). In order for MNCH programming to be more effective in Western Africa, it needs to aim to be gender-specific or gender-transformative, integrating gender norms, roles and relations to insure that interventions target and benefit specific groups (gender-specific) while promoting gender equality and addressing the causes of gender-based health inequalities (gender-transformative) (51).

In addition to the lack of inclusion of important gender issues within MNCH service provision, the reviewed programs often fail to move beyond geographical, educational and socio-economical differences in populations. Due to this omission, populations that do not receive adequate care continue to exist. For example, no reviewed program directs its services toward handicapped populations, who likely experience increased difficulty in finding transport to health care facilities, or may be marginalized by their communities due to the elevated level of care such individuals typically require. Other characteristically disadvantaged populations, which should be targeted, but generally are unheeded include, among others, both younger and older mothers, female-headed households, and unemployed or those who do not retain formal employment in urban settings. By specifically addressing the underserved needs of these overlooked populations, rather than

[5] Agency for the Execution of Works of Public Interest

implementing nation-wide programs, countries in West Africa will improve maternal and child health in the region by serving those possessing the greatest needs.

Future Steps

Targeting disadvantaged populations that continue to be overlooked in the region represents the next step for MNCH programming in West Africa. Due to the successes of many of the reviewed programs, this most likely will not require the development of new types of service provisions and MNCH programs. Rather, to best utilize available resources, organizations and governments should pursue the scale-up of existing programs, while modifying them to best serve those who have the greatest needs. To achieve this will necessitate, improved communication among governments and organizations to ensure that duplication of initiatives does not occur, and that correct resources are applied toward proper populations. Additionally, during program development, gender and equity need to be considered as part of the decision-making process. As uncovered by this review, currently programs often target populations that are too general in nature – those in rural areas, the poor or women – rather than striving to understand the complex power structures within their societies, which lead to disadvantages in health status.

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